Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies, Speech/ Language Pathologists, Physical and Occupational Therapists

Subject: Revised DME Index for Therapy Providers

Date: July 15, 1993
Code: MAPB-093-030-D

**Department of Health and Social Services, Division of Health,
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I. UPDATED DURABLE MEDICAL EQUIPMENT (DME) INDEX

Attached is an updated DME Index effective for dates of service on or after August 1, 1993. This DME Index completely replaces the DME Index issued on September 28, 1992. The changes to the DME Index include the following:

- National HCPCS (HCFA Common Procedure Coding System codes) are now used wherever possible;
- Deleted HCPCS codes are removed from the Index. New HCPCS codes are added to keep the DME Index current with changes in the HCPCS coding system; and
- There are changes in life expectancy limitations, prior authorization requirements, procedure code descriptions, purchase/rental limitations, and recipient copayment amounts.

Please consult the Index for information concerning the above. Numerous changes have occurred with this Index.

II. ADDITIONAL PROCEDURE CODES BILLABLE BY THERAPY PROVIDERS

The following additional procedure codes are billable for therapy providers effective for dates of service on or after August 1, 1993:

Rehabilitation Agencies and Physical Therapy:

E0731
E0746

Rehabilitation Agencies, Physical and Occupational Therapy:

L1844
L2114
W6865

III. BILLING FOR DELETED/OBSOLETE PROCEDURE CODES WHICH HAVE A CURRENT APPROVED PRIOR AUTHORIZATION

Deleted/obsolete codes which have an approved prior authorization number are billable for dates of service up to the prior authorization expiration date or until July 1, 1994, whichever date comes first. Providers must bill using the procedure code and modifier (where applicable) on the approved prior authorization request.

Note: New prior authorization requests are not approved for deleted codes or obsolete codes effective August 1, 1993. If unsure what code to use for a prior authorization request, consult the DME Index for current codes.

IV. PRIOR AUTHORIZATION FOR WHEELCHAIRS: EVALUATION BY A THERAPIST

According to HSS 101.03(96m)(7), medical services cannot be provided solely for the convenience of the recipient, the recipient's family, or a provider. When a DME vendor is originating the purchase of equipment and requests a therapist evaluation to justify that purchase, that evaluation is not separately reimbursable by the WMAP.

V. CONSISTENT BILLING PROCEDURES BETWEEN EMC AND PAPER CLAIMS FOR DME RENTAL AND PURCHASE

A. Rental

Effective for dates of service on or after August 1, 1993, rental services billed to the WMAP must have "to" and "from" dates of service, and be ranged within the same calendar month per detail or the services are denied. This requirement does not apply to crossover claims.

B. Purchase

Indicate only one specific date of service for each purchase, not a range of dates (a range of two consecutive dates is acceptable e.g., October 1, 1993 - October 2, 1993.) This requirement does not apply to the exceptional supply codes (W6890 and W6893).

VI. DELETION OF PRIOR AUTHORIZATION FOR INFANT'S AND CHILDREN'S ORTHOPEDIC SHOES

The prior authorization requirement for infant's and children's orthopedic shoes has been deleted effective for claims received on or after August 1, 1993. The WMAP reimburses providers for orthopedic shoes for infants and children meeting the diagnosis requirements. Providers must indicate one or more of the approved diagnoses or clinical conditions in element 21 of the HCFA 1500 Claim Form or the claim will be denied. Refer to Attachment 2 for the list of diagnoses or clinical conditions.

VII. CHANGES IN PRIOR AUTHORIZATION LIMITS

A lower prior authorization dollar threshold has been established for additional procedure codes effective for dates of service on or after August 1, 1993. Refer to Attachment 1 for a list of these codes. Claims for these services which exceed the new dollar threshold and are submitted without a prior authorization number are denied.

VIII. CHANGES TO REIMBURSEMENT LIMITS FOR CERTAIN ORTHOTIC SUPPLIES

The reimbursement limit for certain supplies (knee joints, drop lock retainers, and knee control condylar pads) used in making orthoses has been increased to four. The WMAP reimburses providers for up to two such supplies per orthosis, for a total of four within the life expectancy of the item. The procedure codes affected are: L2182, L2184, L2186, L2200, L2210, L2220, L2375, L2380, L2385, L2390, L2395, L2405, L2415, L2425, L2435, L2492, L2785, and L2810.